VA MEDICAL CENTER KANSAS CITY

TESTIMONY OF

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HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

June 17, 2002

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to report on the results of our review of the Kansas City VA Medical Center (KCVAMC). At the request of the Secretary of Veterans Affairs, the Office of Inspector General (OIG) conducted a review to determine if: (i) significant deficiencies existed in the sanitary conditions at the medical center, (ii) any deficiencies found had an effect on the quality and outcomes of medical care for patients treated, and (iii) corrective actions were taken to implement the recommendations made in our report of the Combined Assessment Program (CAP) Review of the Kansas City VA Medical Center, dated January 2, 2002.

We conducted our onsite review from April 1st through April 10, 2002 and our report (Report on Medical Center Sanitation and Follow-up of the Combined Assessment Program Review, Kansas City VA Medical Center) presents our analysis of the medical center's Environment of Care and the progress made by the medical center in implementing our prior CAP recommendations. The appendices to the report, provide further explanation of the internal and external reviews performed at the medical center over the past 5 years, an analysis of the quality of care as it relates to the reported pest infestations and infection control, pictures of some of the unsanitary and unsafe conditions found during our review, and finally VA's management's responses to our recommendations. A Report of Administrative Investigation, (Leadership Issues Relating To Cleanliness and Sanitation Conditions, Kansas City VA Medical Center and VISN 15, Kansas City, Missouri) was also completed and presents our finding that the housekeeping deficiencies at the medical center were a result of the prior Director's decision to give funding priority to construction projects and staffing needs that more directly related to quality of care and patient satisfaction rather than to housekeeping.

Environment of Care

KCVAMC management did not maintain the medical center at appropriate levels of cleanliness or rid the medical center of pests. The unclean conditions date back to at least October 1997; were discussed among medical center management, staff, and patients; and, were well documented in medical center records. Management of the Heartland Veterans Integrated Service Network (VISN 15) was also aware of the poor sanitary conditions and pest control problems at the KCVAMC.

Medical center electronic messages (e-mail) show that KCVAMC management was aware of some insect and rodent infestations dating back to July 1993. E-mail messages describe incidents involving rodents and insects in the Surgical Intensive Care Unit (SICU), operating room (OR), and patient ward areas in 1993, 1994, and 1995. However, reports of filthy clinical areas, fruit flies, gnats, flies, wasps, and rodents began appearing in e-mail messages and committee minutes with more frequency in 1998. These records document discussions of these problems from calendar years 1998 through January 2002 involving the former Medical Center Director, key clinical managers and providers, environmental and infection control managers, and patients.

In October 1997, the medical center received a consultant's report, requested by the Chief of Facilities, that stated the Housekeeping Department was understaffed, needed training for managers and staff, and was not organized to deliver quality service. The consultant found a staffing shortage of approximately 16 Full Time Equivalent Employees (FTEE) existed based upon the number of square feet that needed to be maintained. At the time the consultant's performed the study, medical center records indicated that Housekeeping had 42 FTEE. The consultant's report also recommended that management:

- Restructure job descriptions to meet the staffing objectives of the medical center.
- Establish a Housekeeping equipment preventive maintenance program.
- Hire intermittent employees to provide relief for permanent staff on leave.
- Establish a comprehensive project or periodic program, which provides for preventive maintenance of floors and walls.
- Develop a quality assurance program.
- Provide specific supervisory and staff training on proper cleaning techniques and chemical use.

- Establish supervisory responsibility for functional activities like training and cleaning geographical areas of the medical center.

The consultant's recommendations were not implemented. In fact, staffing in Housekeeping ranged from 42 full-time in April 1997; to a high of 45 full-time, 3 part-time, and 13 intermittent in March 1999; and to a low of 36 full-time, 1 part-time, and 6 intermittent in June 2000. At the time of our review, Housekeeping staffing was reported for March 2002 as 44 full-time, 1 part-time, and 2 intermittent.

In addition, senior managers were advised of cleanliness and pest infestation problems over a number of years. Some examples include:

- July 16, 1998 – The Infection Control Nurse reported that the entire Canteen needed to be "terminally cleaned." The report stated that a complete shut down was needed until all areas of the Canteen were entirely clean. "The dirt build up has been permitted for too long."

- October 16, 1998 – A Quality Improvement Team report identified cleanliness problems in the intensive care units (ICUs), recommended that the responsibilities of Environmental Management Service (EMS) workers and ICU staff regarding the "cleanliness and orderliness" of the units be identified, and noted the need for an ongoing monitoring program to maintain cleanliness and orderliness of the units on a daily basis.

- November 3, 1998 – An Infection Control Committee (ICC) memorandum to the Environment of Care Committee stated that it was evident the EMS was not thoroughly cleaning rooms. In addition, there was an apparent lack of knowledge on the part of EMS staff as to what needed to be cleaned and how. A lack of overall supervision contributed to the confusion on the part of housekeepers as to proper cleaning procedures and there was inadequate staffing of EMS personnel for the ICUs.

- November 9, 1998 – ICC minutes noted the following actions were recommended to the KCVAMC top management: (i) reevaluate/readjust staffing patterns in EMS to include adequate levels, as well as unit-dedicated personnel, to ensure thoroughness and consistency in cleaning of assigned areas; (ii) identify an experienced EMS manager to supervise all housekeeping activities; (iii) establish a detailed schedule of daily, weekly, monthly, quarterly, yearly, etc. cleaning functions; and (iv) provide orientation and recurring training to EMS personnel including training on infection control and other relevant matters.

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- January 11, 1999 – The ICC minutes document that the committee recommended that the Nurse Managers be made solely responsible for determining whether a patient room is clean. The committee

recommended training for employees and supervisors as to what "clean" is and proper cleaning procedures.

- August 16, 1999 – ICC minutes reported that the OR just recently had a new infestation of "meat-eating flies."

- August 22, 2001 – A consultation was requested by the Acting Director in order to prepare the medical center for its upcoming JCAHO inspection. A memorandum to the Acting Director from the Manager, Environmental Programs, Salt Lake City VAMC stated that: staffing and equipment shortages prevent their ability to maintain an aesthetically pleasing environment for patients, visitors, and medical personnel. Cleaning procedures and directives were outdated and staff did not understand their duties. Work assignments should be documented, an inventory (of supplies and equipment) should be made, and procedures describing how to perform tasks should be readily available in each work area for staff reference.

- March 28, 2002 – A white paper (for the record, explaining actions taken to pass JCAHO inspection) from the Deputy Network Director, VISN 15 reported, "…The environmental management staff had a number of vacancies which had been frozen for recruitment. I immediately ordered the full recruitment of those positions as a priority for the medical center. It was immediately clear that even with these positions filled it wouldn't be possible to get the medical center up to standard in the time available. I authorized a contract with a cleaning service to concentrate on the large public areas that didn't require special healthcare cleaning techniques for a one time major overhaul. The existing staff was then able to concentrate on those areas requiring special skills and training." In reference to the August 22, 2001, memorandum, the Deputy Network Director stated: "The experienced manager did find that the EMS portion of Facilities was understaffed for a physical plant the size of Kansas City. However, he found that the lack of front line leadership and misallocation of staff by shifts were larger problems than actual numbers of staff."

As the above chronology demonstrates, the actions that the outside consultant recommended in October 1997 continued to be raised for the next 5 years. However, actions taken by management through March 2002 were concentrated on addressing specific cleaning and pest conditions, and not on the organizational failures that permitted the problems to persist.

Infection Control

We found that KCVAMC management had a program for ongoing surveillance for pathogens of medical importance, took specific effective actions to address

infestation issues and outbreaks of disease, and conducted ongoing training directed toward general and specific infectious disease topics. [1]

As a result of ongoing surveillance, two peaks (outbreaks) in the incidence of Methcillin-Resistant *Staphylococcus aureus* (MRSA), Vancomycin-resistant *Enterococcus* (VRE) and *Clostridium difficile* were noted.

The first outbreak of an increase in infectious disease was identified in May and June of 2000 in the SICU and operating suite, as a result of poor aseptic technique. A re-education program on the maintenance of sterile technique for the relevant health care staff brought an end to the outbreak. The second outbreak in March 2001, on a medical ward, was determined to be the result of a breakdown in housekeeping protocol.[2] This outbreak was controlled by a re-education effort aimed at the housekeeping staff and all who came in contact with patients who were on isolation precautions.[3] To further reduce nosocomial infections (diseases contracted in the hospital), in February of 2001, an antiseptic agent was added to soap used in the medical center.[4] In spite of management's actions to improve hand washing, our review found that many soap dispensers were empty.

Quality of Care

KCVAMC clinical management implemented effective controls to monitor the quality of care provided to patients as the controls related to infectious diseases and infection control. We also found that the care provided to the two patients discussed in an article entitled, "Nasal Myiasis in an Intensive Care Unit Linked to Hospital-Wide Mouse Infestation" was adequate, but that the incidents described occurred because of a recurring pest control problem at the facility.

Follow-Up of the Combined Assessment Program Review

During the review we evaluated management actions taken in response to 13 recommendations made in our January 2002 CAP report. We found that medical center management had implemented recommendations made concerning pharmacy security and contracting for angioplasty procedures. For the remaining 11 areas that were reviewed, we reaffirmed our original recommendation or provided more detailed recommended corrective actions.

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[1] Ongoing surveillance for Methcillin Resistant Staphylococcus Aureus, Clostridium Difficile, Vancomycin-Resistant Enterococcus, and other nosocomial infections is demonstrated in the ICC minutes.

[2] Housekeepers were not changing water and cleaning mop heads before moving on to clean the next patient's room which was under isolation precautions, among other shortcomings in isolation procedures.

[3] Data from the ICC committee and medial staff interviews.

[4] Chlorhexidine Gluconate in the ICUs and soap with Triclosan for other clinical areas

In each case, medical center management and the Assistant Deputy Under Secretary for Health agreed with the recommended action and provided acceptable implementation plans.

Conclusion

We determined that management did not maintain the medical center at appropriate levels of cleanliness or rid the medical center of insects and pests. The unclean conditions date back to at least October 1997; were discussed among medical center management, staff, and patients; and were well documented in medical center records. Management of the Heartland Veterans Integrated Service Network (VISN 15) was also aware of the poor sanitary conditions and pest control at the KCVAMC. These conditions existed because Network and KCVAMC management had not acted aggressively to respond to numerous warnings and incidents brought to their attention for years.

We believe top managers were able to avoid major illnesses at KCVAMC only because of the dedicated efforts of the healthcare team who compensated for the lack of aggressive pest management actions and institutional housekeeping support.

In response to our report the Secretary concurred with our recommendation to ensure that managers are held accountable for the sanitation of the VA Medical Center Kansas City. The Under Secretary for Health has stated that he will closely monitor the implementation of the plan of corrective action developed by the Acting Network Director and Medical Center Director.

This concludes my testimony. I would be pleased to answer any questions that you and the members of the subcommittee may have.